

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043165

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 35 Primary Registration District No. 3011 Registrar's No. 126

FILED DEC 10 1963

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Carrollton</b>		Length of stay in 1b <b>30 years</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2nd &amp; Sloan St</b>		d. STREET ADDRESS (If outside, give location) <b>2nd and Sloan St.</b>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Daisy Benjamin Ferrenzo</b>			4. DATE OF DEATH Month Day Year <b>Nov. 26, 1963</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/1888</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (City and state or country) <b>Carroll Co. Mo.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Jacob Benjamin</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Smith</b>	
14. NAME OF HUSBAND OR WIFE <b>Angelo Ferrenzo</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <b>No</b>		16. SOCIAL SECURITY NO. <b>William Benjamin Flint, Michigan</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease with acute congestive failure.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized Arteriosclerosis</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		

21. I attended the deceased from **November 25, 1963**, to **November 26, 1963**. I last saw her alive on **Nov. 25, 1963**.  
Death occurred at **8 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>John H. Platz, M.D.</b>	22b. ADDRESS <b>Carrollton, Missouri</b>	22c. DATE SIGNED <b>11-28-63</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/28/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Carrollton, Missouri</b>
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24. FUNERAL DIRECTOR <b>Marshall Funeral Home Carrollton</b>	25. DATE RECD. BY LOCAL REG. <b>11-28-63</b>	26. REGISTRAR'S SIGNATURE <b>Mary Dean</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

10171

20171

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*R. M. Marshall Jr.*

Licensed Embalmer No. \_\_\_\_\_

*4469*

P. O. Address \_\_\_\_\_

*Carrollton Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.